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522.003: Adoption Assistance and Foster Care Maintenance

Any child placed in subsidized adoption or foster care under Title IV-E of the Social Security Act is automatically eligible for medical assistance provided by the state where the child resides.

(A) Children receiving state-subsidized adoption payments from a state that is a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA) will be eligible for medical assistance provided by the state where the child resides if that state is a member of ICAMA.

(B) Children receiving state-subsidized adoption payments from a state that is not a member of ICAMA, or any child receiving state-subsidized foster-care payments will only be eligible for medical assistance provided by his or her state of origin.

522.004: Children's Medical Security Plan (CMSP)

(A) Regulatory Authority. The Children's Medical Security Plan (CMSP) is administered pursuant to M.G.L. c. 118E, §10F.

(B) Overview. CMSP provides coverage to uninsured children under age 19 who do not qualify for any other MassHealth coverage type, other than MassHealth Limited, and who do not have physician and hospital health-care coverage. To apply for these benefits, an applicant must submit a Medical Benefit Request (MBR) as described in 130 CMR 502.001 and 502.002.

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(C) Eligibility Requirements. Children are eligible for CMSP if they are:

(1) a resident of Massachusetts, as defined in 130 CMR 503.002;

(2) under age 19;

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(3) not otherwise eligible for any other MassHealth coverage type, other than MassHealth Limited. Children who are in a waiting period as described at 130 CMR 505.005(H) are considered not eligible for any other MassHealth coverage type. However, children who are otherwise eligible and who are not receiving MassHealth coverage as a result of not complying with administrative requirements of MassHealth are not eligible for CMSP. Children who lose eligibility for MassHealth Family Assistance as a result of nonpayment of premiums or as a result of not enrolling in employer-sponsored health insurance through Premium Assistance are not eligible for CMSP; and

(4) uninsured. An applicant or member is uninsured if he or she does not have insurance that provides physician and hospital health-care coverage, insurance that is in an exclusion period, or insurance that has expired or has been terminated.

(D) Premiums.

(1) The following premiums apply to those who are determined eligible for CMSP:

Premium Group by % of Federal Poverty Level	Premium
Less than or equal to 199.9%	No monthly charge
200.0% to 300.9%	$7.80 per child per month; family group maximum $23.40 per month
301.0% to 400.0%	$33.14 per family group per month
Greater than or equal to 400.1%	$38.99 per child per month

(2) Failure to pay the applicable monthly premium will result in termination from CMSP.

(3) Assignment to a premium group is determined by comparing the gross family group income to the applicable income level. A family group includes all children under age 19, including unborn children, living in the household and their parents or guardian. A parent may be a natural, step, or adoptive parent.

(E) Copayments. Members are required to pay copayments for certain covered services. There are no required copayments for preventive and diagnostic services. No member will be exempt from copayment requirements.

(1) The copayments for prescription drugs are:

(a) $3 for each generic drug prescription; and

(b) $4 for each brand-name drug prescription.

(2) The copayments for dental services are:

(a) $2 for members with income equal to or below 199.9% of the federal poverty level (FPL);

(b) $4 for members with income 200.0% to 400.0% FPL; and

(c) $6 for members with income equal to or greater than 400.1% FPL.

(3) The copayments for medical (nonpreventive visits) and mental health services are:

(a) $2 for members with income equal to or below 199.9% FPL;

(b) $5 for members with income 200.0% to 400.0% FPL; and

(c) $8 for members with income equal to or greater than 400.1% FPL.

(F) Medical Coverage Date. Except as provided at 130 CMR 522.004(H), coverage begins on the date of the final eligibility determination. The time standards for determining and redetermining eligibility are described at 130 CMR 502.005 and 502.007.

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(G) Benefits Provided. Benefits provided are described at M.G.L. c. 118E, §10F. Included benefits are:

(1) preventive pediatric care;

(2) sick visits;

(3) office visits, first-aid treatment, and follow-up care;

(4) provision of smoking prevention educational information and materials to the parent, guardian, or the person with whom the enrollee resides, as distributed by the Department of Public Health;

(5) prescription drugs up to $200 per state fiscal year;

(6) urgent care visits, not including emergency care in a hospital outpatient or emergency department;

(7) outpatient surgery and anesthesia that is medically necessary for the treatment of inguinal hernia and ear tubes;

(8) annual and medically necessary eye exams;

(9) medically necessary mental-health outpatient services, including substance-abuse treatment services, not to exceed 20 visits per fiscal year;

(10) durable medical equipment, up to $200 per state fiscal year, with an additional $300 per state fiscal year for equipment and supplies related to asthma, diabetes, and seizure disorders only;

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(11) dental health services, up to $750 per state fiscal year, including preventive dental care, provided that no funds will be expended for cosmetic or surgical dentistry;

(12) auditory screening;

(13) laboratory diagnostic services; and

(14) radiologic diagnostic services.

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(H) Enrollment Cap. The MassHealth agency may limit the number of children who can be enrolled in CMSP. When the MassHealth agency imposes such a limit, applicants will be placed on a waiting list when their eligibility has been determined. When the MassHealth agency is able to open enrollment for CMSP, the MassHealth agency will process the applications in the order they were placed on the waiting list.

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522.005: Healthy Start Program (HSP)

(A) Regulatory Authority. The Healthy Start Program (HSP) is administered pursuant to Chapter 26 of the Acts of 2003 and M.G.L. c. 118E, §10E.

(B) Overview. To lower the infant mortality rate, HSP provides payment for health-care benefits to eligible low-income pregnant women, providing them with early, continuous, and comprehensive prenatal, postpartum, and maternity care. To apply for these benefits, an applicant must submit a Medical Benefit Request (MBR) as described in 130 CMR 502.001 and 502.002.

(C) Eligibility Requirements.

(1) Pregnant women and their unborn children are eligible for HSP if their family group gross income is less than or equal to 200% of the federal poverty level and they are:

(a) a resident of Massachusetts, as defined in 130 CMR 503.002;

(b) not otherwise eligible for any other MassHealth coverage type, other than MassHealth Limited; and

(c) not insured for medical care, or have health-care insurance that does not cover all medically necessary pregnancy-related care offered by HSP, as described at 130 CMR 522.005(F).

(2) A family group includes all children under age 19, including unborn children, living in the household and their parents. A parent may be a natural, step, or adoptive parent.

(D) Period of Eligibility.

(1) For those determined eligible, coverage begins on the 10th day before the date a completed Medical Benefit Request (MBR) is received at the Central Processing Unit (CPU). If a Request for Information is needed to complete an MBR, all verifications must be received within 60 days of the date of the Request for Information. The time standards for determining and redetermining eligibility are described at 130 CMR 502.005 and 502.007.

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(2) Once eligibility has been established, benefits for an eligible member will continue throughout the pregnancy, and postpartum care continues for 60 days following the termination of the pregnancy plus an additional period extending to the end of the month in which the 60-day period ends provided eligibility requirements continue to be met. An increase in income above 200% FPL will not cause loss of coverage. A temporary absence from the state will not cause loss of coverage.

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(E) Calculation of Financial Eligibility. Financial eligibility for HSP is determined by comparing the family group's gross monthly income with the applicable income standard.

(F) Benefits Provided. Benefits provided are described at M.G.L. c. 118E, §10E and include all medical care necessary to maintain health during the course of the pregnancy and delivery. Benefits include the following:

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(1) primary and specialty visits;

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(2) outpatient behavioral health visits (up to 10 visits per pregnancy);

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(3) radiology and laboratory visits;

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(4) amniocentesis;

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(5) durable medical equipment and supplies, up to $300 per pregnancy;

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(6) home nursing visits (two visits for pregnancies without complications and five visits for pregnancies with complications or C-sections);

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(7) office visits (including family planning);

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(8) inpatient delivery and services (covered by MassHealth Limited);

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(9) postpartum obstetric and gynecological care;

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(10) newborn hospital and outpatient care, including one postpartum pediatric ambulatory visits;

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(11) prescription drugs; and

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(12) emergency services (covered by MassHealth Limited).

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